**HEALTH ECONOMIC MODULE**

At the conclusion of this module, students should be able to:

* define fraud and abuse and recognize common types;
  + Fraud
    - Definition of Health Care Fraud
      * In general, fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person’s own benefit or for the benefit of some other party.
      * In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of material facts.
    - What is Fraud?
      * Fraud schemes range from solo to broad-based operations. Anyone can commit health care fraud. You may even know someone who has committed fraud. People convicted of fraud include:
        + A Durable Medical Equipment (DME) business owner convicted of health care fraud and anti-kickback violations after submitting more than $4.3 million in fraudulent claims;
        + A chiropractor sentenced to prison for allegedly submitting false and fraudulent claims to several medical insurers, including Medicare;
        + A doctor sentenced to prison after pleading guilty to receiving cash kickbacks in exchange for beneficiary information used to submit claims to Medicare;
        + A hospital executive director who paid $64,000 for causing claims to be submitted to Medicare in violation of the Physician Self-Referral Law (Stark Law); and
        + A podiatrist sentenced to 2 years in prison after pleading guilty to health care fraud for billing Medicare for more complex procedures than were actually performed on beneficiaries.
      * The Office of Inspector General (OIG) of the Department of Health & Human Services (HHS) has created a Most Wanted Fugitives website that profiles the top 10 health care fraud and abuse fugitives. For more information, visit http://oig.hhs.gov/fraud/fugitives on the Internet.
      * Medicare fraud isn’t limited to the medical field. Corporations and organized crime networks commit fraud, robbing the Medicare Program of millions.
      * A major pharmaceutical manufacturer pleaded guilty to misbranding and paid $600 million to resolve criminal and civil liability from its promotion of a certain drug. Part of the settlement resolved allegations that the company misled doctors about the drug’s safety and success and instructed them to miscode claims to ensure payment by Federal Government health care programs. The company also allegedly paid kickbacks to doctors.
      * In another case, 73 defendants were charged when investigators uncovered an organized crime ring’s scheme that allegedly involved more than $163 million in fraudulent billings and identity theft of thousands of beneficiaries and doctors.
    - Examples of Medicare Fraud
      * Examples of actions that **may** constitute Medicare fraud include:
        + Knowingly billing for services that were not furnished and/or supplies not provided, including billing Medicare for appointments that the patient failed to keep; and
        + Knowingly altering claims forms and/or receipts to receive a higher payment amount.
  + Abuse
    - What is Abuse?
      * Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.
      * Both fraud and abuse can expose providers to criminal and civil liability.
    - Examples of Abuse
      * Examples of actions that **may** constitute Medicare abuse include:
        + Misusing codes on a claim,
        + Charging excessively for services or supplies, and
        + Billing for services that were not medically necessary.
  + Summary
    - Fraud and abuse drains billions of dollars from the Medicare Program each year, putting beneficiaries’ health and welfare at risk by exposing them to unnecessary services, taking money away from care, and increasing costs.
    - Fraud and abuse jeopardizes quality health care and services and threatens the integrity of the Medicare Program by fostering the misconception that Medicare means “easy money.”
    - Fraud and abuse costs you, the health care provider and taxpayer. Unfortunately, your taxes finance criminal activities against the Medicare Program and unnecessary spending.
    - Fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program.
  + Review Questions
    - If you make a false statement of material fact to obtain some benefit, for which no entitlement would otherwise exist, for someone **other** than yourself, you have **not** committed Medicare fraud. **FALSE**
    - Medicare abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. **TRUE**
    - An occupational therapist failed to document the order, plan of care signed by the ordering physician, or treatment notes for therapy visits billed to Medicare. This occupational therapist probably committed fraud or abuse. **TRUE**
* describe liability and penalties resulting from fraud and abuse;
  + Medicare Fraud and Abuse Laws
    - The FCA (False Claims Act), Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), Social Security Act, and the U.S. Criminal Code are the main laws used to address Medicare fraud and abuse. Sanctions for noncompliance may result in:
      * Recoupment of any payment made by Medicare for claims,
      * Civil Monetary Penalties (CMPs),
      * Exclusion from participation in all Federal health care programs, and
      * Criminal and civil liability.
  + False Claims Act (FCA)
    - The FCA (31 United States Code [U.S.C.] Sections 3729-3733) protects the Federal Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The “knowing” standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. The following are examples of FCA violations:
      * A Durable Medical Equipment (DME) business owner was convicted of 19 counts of health care fraud and anti-kickback violations after submitting more than $4.3 million in fraudulent claims to Medicare and Medicaid for power wheelchairs and other supplies. The culprit bought Medicare and Medicaid beneficiary referrals. Fraudulent claims were submitted for over 2 years for medically unnecessary supplies (that were often not ordered by a physician and not delivered to the beneficiary). In some cases, the claims were submitted for deceased beneficiaries.
      * A chiropractor was sentenced to 70 months in prison, 3 years probation, and ordered to pay a $1,500 special assessment on 14 counts of health care fraud and one count of money laundering. The chiropractor allegedly submitted false and fraudulent claims to 14 medical insurers, including Medicare. The victims identified more than $2 million paid on fraudulent and unsubstantiated claims.
    - You do not have to intend to defraud the Federal Government to violate the FCA. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Federal Government as a result of the false claims. There is also a criminal FCA (18 U.S.C. Section 287). Criminal penalties for submitting false claims may include imprisonment, fines, or both.
  + Anti-Kickback Statute
    - The Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Kickbacks may include:
      * Cash for referrals,
      * Free rent or below fair-market value rent for medical offices
      * Free clerical staff, and
      * Excessive compensation for medical directorships
    - In kickback cases, the Office of Inspector General (OIG) may seek up to $50,000 for each illegal action and damages of up to 3 times the amount of the payment at issue (regardless of whether some of the payment was legal).
    - If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute. The safe harbor regulations are set forth at 42 Code of Federal Regulations (CFR) Section 1001.952. For more information, visit http://oig.hhs.gov/  
      compliance/safe-harbor-regulations on the Internet.
  + Physician Self-Referral Law (Stark Law)
    - The Physician Self-Referral Law (Stark Law) (42 U.S.C. Section 1395nn) prohibits doctors from referring Medicare beneficiaries for certain designated health services (e.g., clinical laboratory services, physical therapy, and home health services) to an entity in which the doctor (or one of the doctor’s immediate family members) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Examples include:
      * Ownership/investment in a business
      * Compensation for referrals, and
      * Business connections with family members
    - Penalties include fines as well as exclusion from participation in all Federal health care programs.
  + Physician Self-Referral Disclosure Requirement for Advanced Imaging Services
    - Under the Affordable Care Act, a new requirement was created for health care providers who refer beneficiaries for advanced imaging services. At the time of an in-office physician referral for Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CT), and Positron Emission Tomography (PET), a physician is required to disclose to a beneficiary in writing that the beneficiary may obtain these services from another supplier. The referring physician must provide the beneficiary with a list of five alternative suppliers within a 25-mile radius of the physician’s office location at the time of the referral. These suppliers must provide the imaging services ordered.
  + Criminal Health Care Fraud Statute
    - The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice:
      * To defraud any health care benefit program; or
      * To obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program;
    - in connection with the delivery of or payment for health care benefits, items, or services. Proof of actual knowledge of the law or specific intent to violate the law is **not** required. Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.
  + Medicare Fraud and Abuse Penalties
    - Penalties for Medicare fraud and abuse may include exclusions, CMPs, and sometimes criminal sanctions, including fines and imprisonment, against health care providers and suppliers who have violated the FCA, Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), or Criminal Health Care Fraud Statute.
  + Exclusion Statute
    - The OIG is required to impose **mandatory** exclusion from participation in all Federal health care programs on health care providers and suppliers who have been convicted of certain offenses.
    - Exclusion means that, for a designated period, Medicare, Medicaid, and other Federal health care programs will not pay the provider for services performed or for services ordered by the excluded party except in very limited circumstances.
    - For some offenses, the OIG is required to impose exclusion. These are **mandatory** exclusions. The OIG has discretion to impose **permissive** exclusion on a number of other grounds
  + Mandatory Exclusions
    - The OIG is required to impose exclusion for certain offenses. Mandatory exclusions are imposed for a minimum of 5 years, although aggravating factors could lead to a longer, or even permanent, exclusion. Mandatory exclusions are required for those health care providers and suppliers who have been convicted of:
      * A criminal offense related to delivery of an item or service under a Federal or state health care program;
      * A criminal offense involving patient abuse or neglect;
      * Felony convictions for other health care related fraud, theft, or other financial misconduct; or
      * Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.
  + Permissive Exclusions
    - The OIG has discretion to impose exclusion for offenses that do not fall under a mandatory exclusion. Permissive exclusions vary in length.
    - The OIG may issue permissive exclusions for various actions. Some examples include:
      * Misdemeanor convictions related to health care fraud,
      * Misdemeanor convictions related to controlled substances,
      * Conviction related to fraud in a non-health care program,
      * License revocation or suspension, or
      * Obstruction of an investigation or audit.
    - Now that you’ve learned about the types of offenses for which exclusion may be imposed, let’s look at the consequences of the Exclusions Statute for health care providers who might do business with an excluded party, either as an employer or as a contractor, and how to avoid those consequences.
  + List of Excluded Individuals/Entities (LEIE)
    - Providers and contracting entities have a duty to check the program exclusion status of individuals and entities before entering into employment or contractual relationships.
    - **Institutions that knowingly hire an excluded party are subject to CMPs.** Medicare will not make payment for any services provided by an excluded party, with certain exceptions. Prior to hiring an individual, purchasing supplies, or contracting with an entity (and periodically thereafter), health care providers should use the OIG LEIE.
    - The LEIE identifies parties excluded from Medicare reimbursement and is regularly updated. The list includes information about the provider’s specialty, type of sanction, notice date, and when the sanction ends.
  + General Services Administration (GSA) Excluded Parties Listing System (EPLS)
    - In addition to the OIG LEIE, the GSA EPLS contains information on parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits.
    - OIG compliance guidelines encourage health care providers to check the EPLS prior to hiring an individual, purchasing supplies, or contracting with an entity (and periodically thereafter). Remember, health care providers should check the LEIE and the EPLS prior to making employment and contract decisions because no payment is made for services provided by excluded parties. Let’s look more closely at the payment denial associated with exclusion
  + Denial of Payment Associated with Exclusion
    - No payment will be made by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. No program payment will be made for anything that an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else.
    - The exclusion applies **regardless** of who submits the claims and applies to all administrative and management services furnished by the excluded person.
    - An excluded party that submits claims, or causes claims to be submitted, for items or services furnished during the exclusion period may be charged with a CMP, as well as be denied reinstatement to the Medicare Program.
    - Certain exceptions to payment denial apply in specific situations.
  + Denial of Payment Exceptions
    - If a beneficiary submits claims for items or services furnished, ordered, or prescribed by an excluded party in any capacity after the effective date of the exclusion:
      * Medicare will pay for the first claim submitted by the beneficiary and immediately give the beneficiary notice of the exclusion; and
      * Medicare will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary or after the effective date of the exclusion, whichever is later.
    - The same process applies when claims are submitted by laboratories or DME suppliers for items or services ordered or prescribed by an excluded party.
    - There are also exceptions for certain inpatient hospital, skilled nursing facility, home health, and emergency services.
  + Reinstatement Following Exclusion
    - When exclusion ends, the excluded party may be eligible for reinstatement to the Medicare Program and may apply for reinstatement with the OIG. If reinstatement is denied, the excluded party may reapply after 1 year.
  + Civil Monetary Penalties (CMPs)
    - CMPs may be imposed for a variety of conduct, and different amounts of penalties and assessment may be authorized based on the type of violation at issue. Penalties range from up to $10,000 to $50,000 per violation. CMPs can also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received.
  + Civil Prosecutions and Penalties
    - Depending on the severity of the violation, a civil suit or settlement may include:
      * A CMP for each item or service in non-compliance (or higher amounts where applicable by statute). CMPs increase when Medicare fraud losses are $1 million and above;
      * Assessment payment up to 3 times the amount claimed for each item or service in lieu of damages sustained by the Federal Government;
      * Exclusion from Medicare or any other Federally funded program for a specified time; and/or
      * A Corporate Integrity Agreement (CIA) with the Federal Government. A CIA requires an individual or entity to meet specific goals (e.g., educational plan, corrective action plan, reorganization, etc.). The Federal Government may also impose regular audits.
  + Criminal Prosecutions and Penalties
    - In addition to civil prosecutions and penalties, criminal convictions are available when prosecuting health care fraud. Under the Affordable Care Act, the Department of Justice (DOJ) Sentencing Commission can increase Federal Sentencing Guidelines by 20 percent to 50 percent for health care fraud crimes with more than $1 million in losses. It is a crime to obstruct fraud investigations.
  + Summary
    - The False Claims Act (FCA), Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), Social Security Act, and the U.S. Criminal Code are the main authorities used to address Medicare fraud and abuse.
      * The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The “knowing” standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim.
      * The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving any remuneration in exchange for referrals of Federal health care program business.
      * The Physician Self-Referral Law (Stark Law) prohibits physicians from referring Medicare beneficiaries for certain designated health services to an entity in which the physician (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.
      * The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
      * The Exclusion Statute prohibits the excluded entity from participation in all Federal health care programs. No payment will be made for services provided by excluded parties except in very limited circumstances.
      * Civil Monetary Penalties (CMPs) may be imposed for a variety of conduct, and different amounts of penalties and assessment may be authorized based on the type of violation at issue. Penalties range from up to $10,000 to $50,000 per violation. CMPs can also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received.
      * Providers and contracting entities have an affirmative duty to check for program exclusion status prior to entering into employment or contractual relationships using the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE). OIG recommends checking the General Services Administration (GSA) Excluded Parties Listing System (EPLS) as well.
      * Civil and criminal prosecutions can result in a variety of fines, exclusion, Corporate Integrity Agreements (CIAs), and even imprisonment in criminal cases.
  + Review Questions
    - The main authorities used to address fraud and abuse are the False Claims Act (FCA), the Anti-Referral Statute (Stark Law), the Physician Kickback Law, the Social Security Act, and the U.S. Criminal Code. **FALSE**
    - Which of the following is **not** a possible penalty for Medicare fraud or abuse?
      * Exclusion from participation in all Federal health care programs
      * Imprisonment in criminal cases
      * **Civil Monetary Penalties (CMPs) up to $100,000 per violation—its up to 50,000 per violation**
* describe safeguards to protect against fraud and abuse; and,
  + CMS and Other Entities Are Working to Prevent Medicare Fraud and Abuse
    - The Federal Government is aggressively cracking down on fraud, including efforts to prevent Medicare fraud and abuse. The methods CMS uses for prevention that will be discussed in this Web-Based Training (WBT) course are enhanced Medicare enrollment protections; suspension of payments; and education on Medicare laws, regulations, and policies. (CMS also uses many other methods to prevent fraud and abuse, such as automated prepayment edits of claims and use of predictive analytics technologies that analyze claims data in real time, that are outside the scope of this WBT course.)
    - Other entities, such as the Office of Inspector General (OIG) and Medicare Contractors, produce and offer education for health care providers as well.
    - The Senior Medicare Patrol (SMP), under the Administration on Aging, also plays a role in preventing Medicare fraud and abuse.
  + Enhanced Enrollment Protections
    - To ensure that only qualified individuals and organizations are allowed to enroll or maintain their Medicare billing privileges, newly-enrolling and revalidating providers and suppliers are placed in one of three screening categories: limited, moderate, or high. These categories represent the level of risk for fraud and abuse to the Medicare Program for the particular provider type and determine the degree of screening performed during the processing of the enrollment application.
    - Additionally, certain health care providers must pay an application fee when enrolling in Medicare. A hardship exception is available at the Medicare Contractor’s discretion.
    - CMS has authority to impose a moratorium on new enrollments under certain circumstances.
  + Suspension of Payments
    - CMS has the authority to suspend payments for up to 180 days based on possession of reliable information that an overpayment exists or that payments to be made may not be correct.
    - If a credible allegation of fraud exists, payment may be suspended pending an investigation of the allegations, unless there is good cause not to suspend payments.
  + Medicare Learning Network® (MLN) Medicare Education
    - The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo on the CMS website.
    - The MLN provides a variety of training and educational materials that break down Medicare policy into plain language. The MLN delivers planned and coordinated provider education through the various mechanisms such as MLN Matters® Articles, brochures, fact sheets, web-based training courses, videos, and podcasts.
    - The MLN Provider Compliance web page contains educational products that inform Medicare Fee-For-Service (FFS) Providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. For more information, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/  
      ProviderCompliance.html on the CMS website.
  + Other Medicare Education
    - The OIG provides education, compliance guidelines, advisory opinions, and training at http://oig.hhs.gov/compliance on the Internet.
      * National and local policies and procedures;
      * New Medicare initiatives and significant changes to the Medicare Program; and
      * Issues identified through analysis of provider inquiries, medical review data, claim submission errors, and Comprehensive Error Rate Testing (CERT) Program and Recovery Audit Program data.
  + Senior Medicare Patrol (SMP)
    - Every state has an SMP program of volunteer retired professionals and other senior citizens who are trained to recognize and report instances or patterns of health care fraud.
    - SMP volunteers learn how threats to financial independence and health status may occur when citizens are victimized by fraudulent schemes. These SMP projects partner with the aging network, as well as community, faith-based, tribal, health care, and government organizations. Together, they use a variety of outreach strategies to educate and empower their peers to identify, prevent, and report health care fraud. This knowledge helps seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error, and abuse
  + You Can Assist in the Effort to Prevent Medicare Fraud and Abuse
    - As a health care provider, you play a vital role in the fight against Medicare fraud and abuse.
    - You can help prevent Medicare fraud and abuse by:
      * Providing only medically necessary, high quality services to Medicare beneficiaries;
      * Properly documenting all services provided to Medicare beneficiaries;
      * Correctly billing and coding for services provided to Medicare beneficiaries;
      * Checking the List of Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) before making hiring and contracting decisions; and
      * Complying with all applicable laws and regulations, including Conditions of Participation (CoP), National Coverage Determinations (NCDs), and Local Coverage Determinations (LCDs).
    - Be aware of the potential for fraud and abuse in Medicare Part C, Part D, and in Medicaid, including fraud and abuse related to “dual eligibles.”
      * **Medicare Part C**
        + Medicare Part C, or Medicare Advantage (MA), is a health plan choice available to Medicare beneficiaries. MA is a program run by Medicare-approved private insurance companies. These companies furnish or arrange for the provision of health care services to the beneficiaries who elect to enroll in an MA plan.
        + MA plans must cover all services that Medicare covers with the exception of hospice care. MA plans provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.
      * **Medicare Part D**
        + Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Insurance companies or other companies approved by Medicare provide prescription drug coverage to individuals who live in the plan’s service area.
      * **Medicaid**
        + Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. The term “dual eligibles” refers to individuals who are entitled to or enrolled in Medicare Part A or enrolled in Part B, and who are eligible for Medicaid. Fraud and abuse laws apply to the Medicaid Program and protect Medicaid beneficiaries and dual eligibles.
  + Summary
    - The Centers for Medicare & Medicaid Services (CMS) works to prevent Medicare fraud and abuse through enhanced enrollment processes, suspension of payments, and education for health care providers through the Medicare Learning Network® (MLN).
    - The Office of Inspector General (OIG) provides education, compliance guidelines, and training.
    - The Senior Medicare Patrol (SMP) in every state trains volunteers to detect fraud and to educate others on how to detect fraud.
    - You play a vital role in detecting fraud. Your actions can help protect the Medicare Trust Fund.
  + Review Questions
    - The Centers for Medicare & Medicaid Services (CMS) is \_\_\_\_\_\_\_\_ to prevent Medicare fraud and abuse.
      * Suspending payments to health care providers when there is a credible allegation of fraud
    - You can assist in the effort to prevent Medicare fraud and abuse by \_\_\_\_\_\_\_\_.
      * Providing only medically necessary, high quality services to Medicare beneficiaries.
      * Properly documenting all services provided to Medicare beneficiaries.
      * Correctly billing and coding for services provided to Medicare beneficiaries.
      * **All of the above.**
* Detecting Medicare Fraud and Abuse
  + The Role of Data in Detecting Medicare Fraud and Abuse
    - Most of the claim-reviewing and investigating entities that will be discussed in this module use data to target their efforts to high-risk areas. Data analysis can point to high-risk services, geographic locations, and/or provider types. Data analysis can even identify specific outlier health care providers that are billing differently than other similar health care providers in a statistically significant way.
    - While data analysis provides guidance for claim-reviewing and investigating entities, some reviews and investigations are initiated based on random sampling, reports of suspected fraud, and other reasons
  + Integrated Data Repository (IDR)
    - The IDR creates an integrated data environment that contains data from Medicare and Medicaid claims, beneficiary data, provider data, Medicare Advantage (MA) plan data, Part D Prescription Drug Event (PDE) data, and other data as needed.
    - The IDR provides greater information sharing, broader and easier access, enhanced data integration, increased security and privacy, and strengthened query and analytic capability by building a unified data repository for reporting and analytics.
  + Claim-Reviewing Entities
    - Several different entities possess authority from CMS to conduct prepayment and/or postpayment review of claims. These include:
      * Medicare Carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs);
      * Program Safeguard Contractors (PSCs)/Zone Program Integrity Contractors (ZPICs);
      * Comprehensive Error Rate Testing (CERT) Contractors; and
      * Recovery Audit Program Recovery Auditors.
    - If you are contacted by any of these entities, respond to the request for documentation within the specified time frame and with all the documentation requested to support the medical necessity of the services on the claim. This will ensure accurate payment of the claim(s) under review.
  + Medical Review (MR)
    - Medicare Carriers, FIs, and MACs conduct MR of claims to reduce payment errors by identifying and addressing provider coverage and coding mistakes.
    - MR may be conducted before any payment is made on the claim (prepayment) or after payment has been made (postpayment). Medicare Carriers, FIs, and MACs may review one claim at a time or multiple claims at the same time.
    - Some providers may undergo probed reviews or be placed on Progressive Corrective Action (PCA) plans depending on the extent of billing errors found by the Medicare Carriers, FIs, and MACs.
  + Comprehensive Error Rate Testing (CERT) Program
    - The CERT Program produces a national Medicare Fee-For-Service (FFS) error rate. CERT randomly selects a statistically-valid sample of Medicare FFS claims and reviews those claims and related medical records for compliance with Medicare coverage, payment, coding, and billing rules. In order to accurately measure the performance of the Medicare Carriers, FIs, and MACs and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims error rate and a provider compliance error rate and publishes the results of these reviews annually. For example, CMS estimated that 7.8 percent of the Medicare FFS claims it paid in Fiscal Year (FY) 2009 did not meet program requirements, resulting in $23 billion in overpayments.
    - Data produced by CERT is used to identify high-risk areas. CMS and Medicare Contractors produce education on those areas identified by CERT as high risk.
  + Recovery Audit Program
    - Recovery Auditors for Medicare Part A and B conduct postpayment review of claims to detect improper underpayments and overpayments. CMS designated four Recovery Auditors, each assigned to a specific geographic region. Recovery Auditors may target the claims they review by service. Each Recovery Auditor publishes the services being targeted on its website. For more information, including contact information for Medicare Part A and Part B Recovery Auditors, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program on the CMS website.
    - Common Medicare Part A and B Recovery Audit findings are described, along with tips for avoiding the finding, in Quarterly Provider Compliance Newsletters. For an archive of the Newsletters, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL\_Archive.pdf on the CMS website.
    - CMS recently designated one Recovery Auditor to review payments associated with Medicare Part D. CMS will start the Recovery Audit Program associated with Medicare Part C payments in the future.
  + Investigating Entities
    - The following entities review claims **and** also investigate more extensively specific health care providers:
      * PSCs (program safeguard contractors)/ZPICs (zone program integrity contractors),
      * Office of Inspector General (OIG),
      * Department of Justice (DOJ), and
      * Health Care Fraud Prevention and Enforcement Action Team (HEAT).
    - These entities work together and with the claim reviewing entities previously discussed. These entities work together along with CMS to protect the Medicare Program against fraud and abuse.
    - MA plans also investigate fraud and abuse in Medicare Part C. Prescription Drug Plans (PDPs) investigate fraud and abuse in Medicare Part D. Medicare Drug Integrity Contractors (MEDICs) investigate fraud and abuse in Medicare Part C and Part D.
  + Program Safeguard Contractors (PSCs)/Zone Program Integrity Contractors (ZPICs)
    - The PSCs/ZPICs identify cases of suspected fraud and abuse from many sources and refer cases of suspected fraud to the OIG. In addition to referring cases to the OIG, the PSCs/ZPICs may concurrently take action to minimize the potential losses to the Medicare Trust Fund and to protect Medicare beneficiaries from any potential adverse effects. Appropriate action varies from case to case.
    - When a provider’s employees file complaints, the PSC/ZPIC will immediately refer that case to the OIG.
  + Office of Inspector General (OIG)
    - The OIG protects the integrity of the Department of Health & Human Services’ (HHS) programs, including Medicare, and the health and welfare of its beneficiaries. The OIG carries out its duties through a nationwide network of audits, investigations, inspections, and other related functions. The OIG has the authority to exclude individuals and entities who have engaged in fraud or abuse from participation in Medicare, Medicaid, and other Federal health care programs, and to impose Civil Monetary Penalties (CMPs) for certain misconduct related to Federal health care programs. The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE)
  + Department of Justice (DOJ)
    - The DOJ investigates fraud and abuse in Federal Government programs. Its investigators partner with the OIG and other Federal, state, and local law enforcement through HEAT to investigate and prosecute Medicare fraud and abuse.
  + Health Care Fraud Prevention and Enforcement Action Team (HEAT)
    - The DOJ and HHS established HEAT to build and strengthen existing programs to combat Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT efforts have included expansion of the DOJ-HHS Medicare Fraud Strike Force that has been successful in fighting fraud. HEAT investigators use new state-of-the-art technology to fight fraud with unprecedented speed and efficiency. HEAT created the Stop Medicare Fraud website, which provides information about how to identify and protect against Medicare fraud and how to report it.
    - The mission of HEAT is:
      * To gather Government resources to help prevent fraud and abuse in the Medicare and Medicaid Programs, and crack down on the fraud perpetrators who abuse the system and cost us billions of dollars.
      * To reduce skyrocketing health care costs and improve the quality of care by ridding the system of perpetrators who prey on Medicare and Medicaid beneficiaries.
      * To highlight best practices by providers and public sector employees who are dedicated to ending fraud and abuse in Medicare.
      * To build upon existing partnerships between the DOJ and OIG, such as the Medicare Fraud Strike Force, to reduce fraud and recover taxpayer dollars.
  + Summary
    - The role of data in detecting Medicare fraud and abuse is to guide claim reviewers and investigators to those areas most at risk for fraud and abuse.
    - Entities that conduct prepayment review of claims include Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and Program Safeguard Contractors (PSCs)/Zone Program Integrity Contractors (ZPICs).
    - Entities that conduct postpayment review include Medicare Carriers, FIs, MACs, PSCs/ZPICs, Comprehensive Error Rate Testing (CERT) Contractors, and Recovery Audit Program Recovery Auditors.
    - Entities that investigate Medicare fraud and abuse include the PSCs/ZPICs, the Office of Inspector General (OIG), the Department of Justice (DOJ), and the Health Care Fraud Prevention and Enforcement Action Team (HEAT).
  + Review Questions
    - Which of the following entities conduct Medical Review (MR) of claims?
      * Medicare Carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs)
      * Comprehensive Error Rate Testing (CERT) Contractors
      * Recovery Audit Program Recovery Auditor
      * **All of the Above**
    - Which of the following entities investigate health care providers suspected of Medicare fraud and abuse?
      * Comprehensive Error Rate Testing (CERT) Contractors
      * Office of Inspector General (OIG)
      * Department of Justice (DOJ)
      * Program Safeguard Contractors (PSCs)/Zone Program Integrity Contractors (ZPICs)
      * **B, C, and D**
* Reporting Medicare Fraud and Abuse
  + How to Report Suspected Medicare Fraud and Abuse
    - The Office of Inspector General (OIG) maintains a hotline that accepts and reviews tips from all sources. If you prefer, you may report your complaint anonymously. No information will be entered in OIG record systems that could trace the complaint to you. In many cases, however, the lack of contact information for the source prevents a comprehensive review of the complaint. The OIG encourages you to provide information on how to contact you for additional information
  + How to Self-Disclose Medicare Fraud and Abuse
    - Providers who wish to voluntarily disclose self-discovered evidence of potential fraud to the OIG may do so under the Provider Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.
    - The OIG endeavors to work cooperatively with providers who are forthcoming, thorough, and transparent in their disclosures in resolving these matters. While the OIG does not speak for the Department of Justice (DOJ) or other agencies, the OIG consults with these agencies, as appropriate, regarding the resolution of SDP issues.
  + How to Self-Disclose Actual or Potential Violations of the Physician Self-Referral Law (Stark Law)
    - The Self-Referral Disclosure Protocol (SRDP) enables health care providers and suppliers to self-disclose actual or potential violations of the Physician Self-Referral Law (Stark Law).
    - The SRDP cannot be used to obtain a Centers for Medicare & Medicaid Services (CMS) determination as to whether an actual or potential violation of the Physician Self-Referral Law (Stark Law) occurred. Thus, a disclosing party should make a submission to the SRDP with the intention of resolving its overpayment liability exposure for the conduct it identified.
    - Under certain circumstances, CMS has the discretion to reduce the amount due.
  + Medicare Incentive Reward Program (IRP)
    - The Medicare IRP was established to encourage reporting of suspected fraud and abuse.
    - The IRP will pay you a reward for information on Medicare fraud and abuse or other punishable activities. The information must lead to a minimum recovery of $100 in Medicare funds from individuals and entities determined by CMS to have committed fraud.
  + Summary
    - You can report suspected Medicare fraud and abuse to the Office of Inspector General (OIG) online, by phone, e-mail, or mail.
    - You can self-disclose fraud and abuse to the OIG using the Provider Self-Disclosure Protocol (SDP). You can self-disclose actual or potential violations of the Physician Self-Referral Law (Stark Law) to the Centers for Medicare & Medicaid Services (CMS) using the Medicare Self-Referral Disclosure Protocol (SRDP).
    - The Medicare Incentive Reward Program (IRP) provides rewards for information on Medicare fraud and abuse or other punishable activities.
  + Review Questions
    - Suspected fraud and abuse must be reported via telephone and is not anonymous. **FALSE**
    - Health care providers who self-disclose violations of fraud and abuse are immune from sanctions and prosecutions. **FALSE**
* **POST TEST**
  + The main authorities that address fraud and abuse are the \_\_\_\_\_\_\_\_.
    - The False Claims Act (FCA), Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), Social Security Act, and the U.S. Criminal Code are the main authorities used to address Medicare fraud and abuse. **ALL OF THE ABOVE**
  + The Centers for Medicare & Medicaid Services (CMS) is working to prevent Medicare fraud and abuse using all of the following methods, except \_\_\_\_\_\_\_\_.
    - A. Enhancing enrollment processes
    - ** B. Suspending payments to providers for 2 years when there is a credible allegation of fraud**.—its actually only 180 days
    -  C. Creating education for health care providers through the Medicare Learning Network® (MLN).
    -  D. Requiring an enrollment application fee for certain types of providers.
* You can assist in the effort to prevent Medicare fraud and abuse by properly and thoroughly documenting all services provided to Medicare beneficiaries.
  + **TRUE**
* A chiropractor, in an intentional attempt to falsely obtain money from the Medicare Program, billed for services she knew were not medically necessary and falsified the beneficiary’s diagnosis on the Medicare claim. Depending on the facts and circumstances, she most likely committed \_\_\_\_\_\_\_\_.
  + ** A. Medicare fraud or abuse.**
  +  B. A violation of the Physician Self-Referral Law (Stark Law).
  +  C. A violation of the Anti-Kickback Statute.
* Medicare abuse includes any practice that is not consistent with the goals of providing patients with all services they request (**for this to be true this should say medically necessary)**, meeting professionally recognized standards, and charging fair prices.
  + **FALSE**
* Suspected fraud and abuse may be reported anonymously to the Office of Inspector General (OIG) via \_\_\_\_\_\_\_\_.
  + You can report suspected Medicare fraud and abuse to the Office of Inspector General (OIG) online, by phone, e-mail, or mail. **ALL OF THE ABOVE**
* Medicare fraud is any act that results in unnecessary costs to the Medicare Program.
  + **FALSE—what is being described is abuse.**
* The best entity for health care providers to self-disclose Medicare fraud or abuse to is the \_\_\_\_\_\_\_\_.
  + **Office of Inspector General (OIG)**
* Possible penalties for Medicare fraud or abuse include \_\_\_\_\_\_\_\_.
  +  A. Imprisonment in criminal cases.
  +  B. Civil Monetary Penalties (CMPs) up to $50,000 per violation.
  +  C. Exclusion from participation in all Federal health care programs.
  + ** D. All of the above.**
* Select the true statement.
  +  A. Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT) Contractors, and the Office of Inspector General (OIG) only review claims and do not investigate health care providers suspected of Medicare fraud and abuse.
  +  B. Medicare Carriers, FIs, MACs, CERT Contractors, and the OIG only investigate health care providers suspected of Medicare fraud and abuse and do not review claims
  +  **C. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Audit Program Recovery Auditors only review claims and generally do not investigate health care providers suspected of Medicare fraud and abuse**
  +  D. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Audit Program Recovery Auditors only investigate health care providers suspected of Medicare fraud and abuse and do not review claims